ANNUAL UTILIZATION REPORT OF HOSPITALS - 2003

1. Facility DBA (Doing Business As) Name:		2. OSHPD Facility No.:	
3. Street Address:	4. City:		5. Zip Code:
6. Facility Phone No.: ( )	7. Administrator Name:	8. Administrator's E-Mail Address:	
9 Was the hospital in operation at any time during the year? Yes ☐ No ☐		Dates of Operation (MMDDYYYY): 10. From: 11. Through:	
12. Name of Parent Corporation:			
13. Corporate Business Address:	14. City:	15. State	16. Zip Code:
17. Person Completing Report		18. Phone No. ( ) Ext.	
19. Fax No. ( )		20. E-mail Address:	

CERTIFICATION

I declare the following under penalty of perjury: that I am the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility; that the records and logs are true and correct to the best of my knowledge and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Date

Administrator Signature

Administrator Name (Please Print)

Completion of the Annual Utilization Report of Hospitals is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility pursuant to Section 70735 and 71533 of Title 22 of the California Code of Regulations. Failure to complete and file this report by February 15 may result in action against the hospital's license.

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
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Sacramento, CA 95814

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Section 2

OSHPD FACILITY ID No. _____

LICENSE CATEGORY (TYPE) (Completed by OSHPD)

Line No.		(1)
1	General Acute Care	
	Acute Psychiatric	
	Psychiatric Health Facility	
	Chemical Dependency Recovery Hospital	

LICENSEE TYPE OF CONTROL

Line No.		(1)
5	From the list below, select the ONE category that best describes the licensee type of control of your hospital and enter the number which appears next to that category.	

LICENSEE TYPE OF CONTROL CODES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (incl. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

PRINCIPAL SERVICE TYPE

Line No.		(1)
25	From the list below, select the ONE category that best describes the type of service provided to the majority of your patients and enter the number which appears next to that category.	

PRINCIPAL SERVICE TYPE CODES

10	General Medical / Surgical	18	Physical Rehabilitation
12	Long-Term Care (SN / IC)	19	Orthopedic or Pediatric Orthopedic
13	Psychiatric	22	Developmentally Disabled
15	Chemical Dependency (Alcohol / Drug)	23	Other
17	Pediatric		

Section 3

OSHPD FACILITY ID No. _____

INPATIENT BED UTILIZATION - *DO NOT INCLUDE NORMAL NEWBORNS IN BED UTILIZATION DATA*

Line No.	Bed Classification and Bed Designation	(1) Licensed Beds (incl. beds in suspense)	(2) Licensed Bed Days	(3) Hospital Discharges (including deaths)	(4) Intra-hospital Transfers from Critical Care	(5) Patient (Census) Days
1	Medical / Surgical (Include GYN)					
2	Perinatal (exclude Newborn / GYN)					
3	Pediatric					
4	Intensive Care					
5	Coronary Care					
6	Acute Respiratory Care					
7	Burn					
8	Intensive Care Newborn Nursery					
9	Rehabilitation Center					
15	**SUBTOTAL - GAC**					
16	Chemical Dependency Recovery Hospital					
17	Acute Psychiatric					
18	Skilled Nursing					
19	Intermediate Care					
20	Intermediate Care / Developmentally Disabled					
25	**HOSPITAL TOTAL**					

CHEMICAL DEPENDENCY RECOVERY SERVICES IN LICENSED GAC AND ACUTE PSYCHIATRIC BEDS *

Line No.	Bed Classification	(1) Licensed Beds		(3) Hospital Discharges		(5) Patient (Census) Days
30	GAC - Chemical Dep Recovery Services					
31	Acute Psych - Chemical Dep Recovery Svcs					

* The licensed services data for these CDRS are to be included in lines 1 through 25 above.

NEWBORN NURSERY INFORMATION

Line No.		(1) Nursery Bassinets		(3) Nursery Discharges		(5) Nursery Days
35	Newborn Nursery					

SKILLED NURSING SWING BEDS (Completed by OSHPD.)

Line No.		(1)
40	Number of licensed General Acute Care beds that were approved for skilled nursing care.	

Section 3 (Con't)

OSHPD FACILITY ID No. _____

COMPLETE THIS SECTION ONLY IF YOUR HOSPITAL HAS LICENSED ACUTE PSYCHIATRIC OR PHF BEDS.
INCLUDE CHEMICAL DEPENDENCY RECOVERY SERVICES PROVIDED IN LICENSED PSYCHIATRIC BEDS.

ACUTE PSYCHIATRIC PATIENTS BY UNIT ON DECEMBER 31

Line No.		(1) Number of Patients
43	Locked	
44	Open	
45	**ACUTE PSYCHIATRIC TOTAL ***	

ACUTE PSYCHIATRIC PATIENTS BY AGE CATEGORY ON DECEMBER 31

Line No.		(1) Number of Patients
46	0 - 17 Years	
47	18 - 64 Years	
49	65 Years and Older	
50	**ACUTE PSYCHIATRIC TOTAL ***	

ACUTE PSYCHIATRIC PATIENTS BY PRIMARY PAYER ON DECEMBER 31

Line No.		(1) Number of Patients
51	Medicare - Traditional	
52	Medicare - Managed Care	
53	Medi-Cal - Traditional	
54	Medi-Cal - Managed Care	
55	County Indigent Programs	
56	Other Third Parties - Traditional	
57	Other Third Parties - Managed Care	
58	Short-Doyle (includes Short-Doyle Medi-Cal)	
59	Other Indigent	
64	Other Payers	
65	**ACUTE PSYCHIATRIC TOTAL ***	

*** ACUTE PSYCHIATRIC TOTAL on lines 45, 50 and 65 must agree.**

SHORT DOYLE CONTRACT SERVICES

Line No.		(1)
70	During the reporting period, did you provide any acute psychiatric care under a Short-Doyle contract?	Yes ☐ No ☐

Section 3 (Con't)

OSHPD FACILITY ID No. _____

INPATIENT HOSPICE PROGRAM

Did your hospital offer an inpatient hospice program during the report period?

Line No.	(1)
71	Yes ☐ No ☐

If yes, what type of bed classification is used for this service? (Check all that apply.)

Line No.	Bed Classification	(1)
72	General Acute Care	
73	Skilled Nursing (SN)	
74	Intermediate Care (IC)	

Section 4

OSHPD FACILITY ID No. _____

EMSA TRAUMA CENTER DESIGNATION (Completed by OSHPD from EMSA data.)

Line No.	EMSA Trauma Designation	(1) Designation	(2) Pediatric
1	Level I		
	Level II		
	Level III		
	Level IV		

LICENSED EMERGENCY DEPARTMENT LEVEL (Completed by OSHPD.)

Line No.	ED Level	(1) Beginning of Period	(2) End of Period
2	Standby		
	Basic		
	Comprehensive		

SERVICES AVAILABLE ON PREMISES (Check all that apply.)

Line No.	Services Available	(1) 24 Hour	(2) On-Call
11	Anesthesiologist		
12	Laboratory Services		
13	Operating Room		
14	Pharmacist		
15	Physician		
16	Psychiatric ER		
17	Radiology Services		

EMERGENCY MEDICAL SERVICE VISITS BY TYPE

Line No.	EMS Visit Type*	CPT Codes	(1) Total	(2) Admitted
21	Minor	99281		
22	Low/Moderate	99282		
23	Moderate	99283		
24	Severe, w/o threat	99284		
25	Severe, w threat	99285		
30	**TOTAL EMS VISITS**			

* DO NOT INCLUDE patients who registered but left without being seen, employee physicals and scheduled Clinic-type visits.

Section 4 (Con't)

OSHPD FACILITY ID No. _____

EMERGENCY MEDICAL TREATMENT STATIONS ON DECEMBER 31

Line No.		(1)
35	Enter the number of emergency medical treatment stations.	

Treatment Station - A specific place within the emergency department adequate to treat one patient at a time. Do not count holding or observation beds.

NON-EMERGENCY (CLINIC) VISITS SEEN IN EMERGENCY DEPARTMENT

Line No.		(1)
40	Enter the number of non-emergency (clinic) visits seen in EMS.	

EMERGENCY REGISTRATIONS, BUT PATIENT LEAVES WITHOUT BEING SEEN*

Line No.		(1)
45	Enter the number of EMS registrations that did NOT result in treatment.	

* Include patients who arrived at ED, but did not register and left without being seen (if available).

EMERGENCY DEPARTMENT CLOSURE / AMBULANCE DIVERSION HOURS

Did your hospital close its ED at any time during the year, resulting in ambulance diversion?

Line No.	(1)
50	Yes ☐ No ☐

If "yes", fill out lines 51 through 65 below.

Enter the number of hours Emergency Department was closed.

Line No.	Month	(1) Hours
51	January	
52	February	
53	March	
54	April	
55	May	
56	June	
57	July	
58	August	
59	September	
60	October	
61	November	
62	December	
65	Total Hours	

Section 5

OSHPD FACILITY ID No. _____

SURGICAL SERVICES

Line No.	Surgical Services	(1) Surgical Operations	(2) Operating Room Minutes
1	Inpatient		
2	Outpatient		

OPERATING ROOMS ON DECEMBER 31

Line No.	Operating Room Type	(1) Number
7	Inpatient only	
8	Outpatient Only	
9	Inpatient and Outpatient	
10	**TOTAL OPERATING ROOMS**	

AMBULATORY SURGICAL PROGRAM

Line No.		(1)
15	Did your hospital have an organized ambulatory surgical program?	Yes ☐ No ☐

LIVE BIRTHS

Line No.		(1) Number
20	Total Live Births (Count multiple births separately)*	
21	Live Births with Birth Weight Less Than 2500 grams (5lbs. 8 oz.)	
22	Live Births with Birth Weight Less Than 1500 grams (3lbs. 5 oz.)	

* TOTAL LIVE BIRTHS on line 20 should approximate the number of Perinatal discharges shown in Section 3, line 2, column 3. Include LDR or LDRP births and C-Section deliveries.

ALTERNATE BIRTHING CENTER INFORMATION

Line No.		(1)
31	Did your hospital have an approved alternate birthing program?	Yes ☐ No ☐
32	If yes, indicate if your alternative setting was approved as LDR and/or LDRP.	LDR ☐ LDRP ☐

OTHER LIVE BIRTH DATA

Line No.		(1) Number
36	How many of the live births reported on line 20 occurred in your alternative setting? Do not include C-Section deliveries.	
37	How many of the live births reported on line 20 were C-Section deliveries?	

Section 5 (con't)

OSHPD FACILITY ID No. _____

LICENSED CARDIOLOGY AND CARDIOVASCULAR SURGERY SERVICES (Completed by OSHPD.)

Line No.		(1) Licensure
41	Cardiovascular Surgery Services (Complete lines 42 to 85, if licensed.)	
	Cardiac Catheterization Only (Complete lines 55 to 85, if licensed.)	
	Not Licensed	

LICENSED CARDIOVASCULAR OPERATING ROOMS

Line No.		(1)
42	Number of operating rooms licensed to perform cardiovascular surgery on December 31.	

CARDIOVASCULAR SURGICAL OPERATIONS
(with and without the HEART/LUNG MACHINE*)

Line No.		(1) Cardio-Pulmonary Bypass USED*	(2) Cardio-Pulmonary Bypass NOT USED
43	Pediatric		
44	Adult		
45	**TOTAL CARDIOVASCULAR SURGICAL OPERATIONS**		

*Also referred to as Extracorporeal Bypass or "on-the-pump" (heart/lung machine).

CORONARY ARTERY BYPASS GRAFT (CABG) SURGERIES*

Line No.		(1)
50	Number of Coronary Artery Bypass Graft (CABG) surgeries performed.	

* Subset of cardiovascular surgeries reported on line 45 above.

CARDIAC CATHETERIZATION LAB ROOMS

Line No.		(1)
55	Number of rooms equipped to perform cardiac catheterizations on December 31.	

CARDIAC CATHETERIZATION VISITS

Line No.		(1) Diagnostic	(2) Therapeutic
56	Pediatric - Inpatient		
57	Pediatric - Outpatient		
58	Adult - Inpatient		
59	Adult - Outpatient		
60	**TOTAL CARDIAC CATHETERIZATION VISITS**		

Section 5 (con't)

OSHPD FACILITY ID No. _____

DISTRIBUTION OF THERAPEUTIC CARDIAC CATHETERIZATION PROCEDURES

Complete this table if Therapeutic Cardiac Catheterization Visits are reported in column 2, line 60.

Line No.		(1) Procedures
71	Permanent Pacemaker Implantation	
72	Percutaneous Transluminal Coronary Angioplasty (PTCA) - WITH Stent	
73	Percutaneous Transluminal Coronary Angioplasty (PTCA) - WITHOUT Stent	
74	Atherectomy (PTCRA - rotablator, DCA, laser, other ablation, etc.)	
75	Thrombolytic Agents (intracoronary only)	
76	Percutaneous Transluminal Balloon Valvuloplasty (PTBA)	
84	All Other (including Radiofrequency Catheter Ablation)	
85	**TOTAL THERAPEUTIC CARDIAC CATHETERIZATION PROCEDURES**	

NOTE: DO NOT INCLUDE ANY OF THE FOLLOWING AS A CARDIAC CATHETERIZATION

- Angiography - Non-coronary
- Automatic Implantable Cardiac Defibrillator (AICD)
- Defibrillation
- Cardioversion
- Intra-Aortic Balloon Pump
- Percutaneous Transluminal Angioplasty - Non-cardiac
- Pericardiocentesis
- Temporary Pacemaker Insertion

MAJOR CAPITAL EXPENDITURES

Section 6

OSHPD FACILITY ID No. _____

Section 127285 (3) of the Health and Safety Code requires each hospital to report "acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000)."

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT ACQUIRED COSTING OVER $500,000

Did your hospital acquire any diagnositc or therapeutic equipment that had a value of $500,000 or more?

Line No.	(1)
1	Yes ☐ No ☐

If "yes", fill out lines 2 through 11 below.

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DETAIL

Line No.	(1) Description of Equipment	(2) Value	(3) Date of Acquisition (MM/DD/YYYY)	(4) Means of Acquisition (Check one.)			
2				Purchase ☐	Lease ☐	Donation ☐	Other ☐
3				Purchase ☐	Lease ☐	Donation ☐	Other ☐
4				Purchase ☐	Lease ☐	Donation ☐	Other ☐
5				Purchase ☐	Lease ☐	Donation ☐	Other ☐
6				Purchase ☐	Lease ☐	Donation ☐	Other ☐
7				Purchase ☐	Lease ☐	Donation ☐	Other ☐
8				Purchase ☐	Lease ☐	Donation ☐	Other ☐
9				Purchase ☐	Lease ☐	Donation ☐	Other ☐
10				Purchase ☐	Lease ☐	Donation ☐	Other ☐
11				Purchase ☐	Lease ☐	Donation ☐	Other ☐

BUILDING PROJECTS COMMENCED DURING REPORT PERIOD COSTING OVER $1,000,000

Section 127285 (4) of the Health and Safety Code requires each hospital to report the "commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars ($1,000,000)."

Did the hospital commence any building projects during the report period which will require an aggregate capital expenditure exceeding $1,000,000?

Line No.	(1)
25	Yes ☐ No ☐

If "yes", fill out lines 26 through 30 below.

DETAIL OF CAPITAL EXPENDITURES

Line No.	(1) Description of Project	(2) Projected Total Capital Expenditure	(3) OSHPD Project No. (if applicable)
26			
27			
28			
29			
30			